Introduction

This manual outlines procedures for submitting Comprehensive Hospital Abstract Reporting System (CHARS) discharge data to the Department of Health (DOH). The rules for reporting hospital inpatient discharge data and the authority for reporting requirements are found in the Washington Administrative Code (WAC) 246-455. (See Appendix A.)

The Manual is organized as follows:

- Introduction
- CHARS overview
- E Codes
- Certification
- UB92 Information
- System Inputs
- System Outputs
- Appendices

Organization and Background

The CHARS system was established in law by the 1984 Legislature. These data were previously collected by the Washington State Hospital Commission which was sunsetted in June 1989. The department was created by the Legislature effective July 1, 1989. In October 1989, the Legislature authorized the department to continue hospital based data collection, storage and retrieval systems as stated in Engrossed Senate Bill (ESB) 6152.

The CHARS system is currently authorized under Revised Code of Washington (RCW) 43.70.052 (Appendix B) and is implemented by Washington Administrative Code (WAC) 246.455. In the department, the Hospital and Patient Data Systems (HPDS) is responsible for performing this function. The mission of HPDS is to collect, maintain, analyze, and disseminate hospital patient discharge and financial utilization data that are useful in conducting public health work and in improving the quality and cost effectiveness of health care for all people in the state of Washington.

Purpose and Objectives

The purpose of the CHARS system is to provide public health personnel, consumers, purchasers, payers, providers, and researchers useful information by which to make informed decisions on health care. The CHARS system provides those concerned with the development of public policy with information necessary to analyze many significant health care issues. Specifically, the department uses the CHARS data system to:

- identify and analyze health trends related to patients' hospitalizations;
- establish statewide diagnosis related groups (DRG) weights;
- create hospital specific case mix indices; and
- identify and quantify issues related to health care access, quality, and cost containment.

Your conscientious efforts in providing accurate data to CHARS enables health providers, policy makers, managers and researchers in our state to better understand our health care problems and to formulate effective solutions for these problems.

CHARS Overview

From the conception of the CHARS system hospital inpatient data were collected using the Uniform Billing (UB) 82 format. On October 1, 1993 the department began data collection in the UB92 format. The system was converted from a mainframe application to a relational database operating system. In August, 1994, the 1993 data were released in the UB92 format.

The CHARS data application is owned and operated by the department and accomplishes the following:

- Provides the department and the health care community with accurate and timely data through mandated requirements.
- Efficiently and accurately accommodates the processing volumes and performance criteria outlined.
- Responds to current Federal UB92/Centers for Medicare and Medicaid Services (CMS) reporting requirements in a timely manner.
- Improves analysis and management capabilities.
- Supports state-level data capture and compilation, and access to an on-line database for query and analysis.
- Manages data flow and processing to accurately track each discharge record or correction from time of receipt to final processing.
- Reduces problems related to data submission.
- Provides flexibility in custom application changes to accommodate future reporting and processing requirements.
- Increases opportunity for information sharing with other related databases.
- Assists with the assessment and evaluation process as outlined in the Washington State Public Health Improvement Plan.
- Provides accurate and timely reports as specified on each sample report.
- Ensures capability of operating on the department's system standards.
- Ensures confidentiality of all patient information.

System Functions

The CHARS system is designed to accommodate data elements from the Medicare provider-billing file and record formats for UB92 (CMS 1450 Version 050 flat file). These inpatient data are processed to produce a range of products. The system includes the following functions:

- **Data Collection:** Hospitals prepare their patient data to conform to the CHARS system's operating structure. The data are submitted to CHARS via the Web-based CHARS data submission system.

- **Data Editing:** The CHARS system uses edits identified by the department. It also implements the Medicare Code Edits (MCE) that are used for editing clinical data. (See Appendix G.) Records that fail the edits are flagged for user correction. Incorrect records remain in the production system pending hospital review and correction.

- **Data Correction:** Records with errors are displayed online. Saving a corrected record re-edits the record and any remaining errors are displayed. The process continues until all errors are corrected. Hospitals can resubmit a complete period of data. If corrections are submitted, the specific period of data in production is deleted and is replaced by the new data. Previous corrections are lost. CHARS uses on-line editing for corrections and adjustments (hospital changes made to the accepted data). When the hospital's entire submission for a given period (half year, full year) is accepted the database is closed. Hospitals certify quarterly that their data are 95% correct for inpatient discharges and dollars.

- **On-Line Data Storage:** The system stores 12 months of data on-line for corrections and adjustments. The system stores the previous year's closed data for reference and reporting. Changes are not made to the database for closed years.

- **Data Reporting:** The released full year data are stored online in the history file in the database. Standard reports are generated from these data. Users can run analytical reports against these data online. Specific data requests and analyses are also performed using these files. Half year and full year public data are released and made available for sale on CD-ROM. Confidential data are also released and can be used for research but only when the request is approved by the Human Research Review Board.

The department is responsible for liaison with the hospitals, and making reports to the hospitals and the health care community available.

System Description

The CHARS system is designed to collect, edit, process, store, retrieve and report data using CMS 1450 UB92 guidelines. Following are characteristics of the CHARS data processing system:

1. Collects hospital inpatient discharges on Bill Types 111, 121 and 181.
2. Applies patient clinical and financial Medicare Code Edits (MCE) and validation of physician UPIN, State license numbers and Medicaid license numbers.
3. Sets error threshold for hospitals as a mechanisms to control data quality. (At present the department accepts 60% but strives for 5 %.)
4. Applies data grading mechanisms using MCEs and the department's edits.
5. Generates Data Quality Reports that allow the submitting facility to review the quality and completeness of data in a submission (e.g., Edit Error Summary, DRG).
6. Allows for data correction and adjustment through on-line record level updates or entire batch resubmission.
7. Provides the ability to delete and add a discharge record using online methods.
8. Allows the department and the hospital to track the progress and status of data submissions.
9. Assigns CMS, MDC, DRG and value-added fields – Washington State weights and case mix indices elements.
10. Provides security to prevent accidental removal or modification of data and provides protection of confidential data.
11. Allows customization of system functions to meet the department's needs (e.g., change physician numbers).
12. Allows users to run specific end-user reports on demand and download products to the user workstation.

CHARS Data Elements

The following describes data elements collected by CHARS and how they appear on-screen to the user. "FL" indicates the Form Locator number referenced in the National Uniform Billing Committee (NUBC) Data Element Specifications as of May 9, 2002.

- **Patient control number** (PCN) (FL # 3)
- **Type of bill** (FL #4)
- **Statement covers period** (FL #6)
- **Patient Name** (FL #12)
- **Patient Address (Zip Code only)** (FL # 13)
- **Patient birthdate** (FL # 14)
- **Patient sex** (FL #15)
- **Admission/Start of Care date** (FL #17)
- **Type of admission/Visit** (FL # 19)
- **Source of admission** (FL # 20)
- **Patient status** (FL # 22)
- **Revenue code** up to 400 (FL #42)
- **Units of service** (FL #46)
- **Total charges** (FL #47)
- **Payer identification # 1** (FL # 50A)
- **Payer identification # 2** (FL #50B)
- **Provider number** (FL#51)
- **Principal diagnosis code** (FL # 67)
- **Other diagnoses codes** up to 8 (FL #68-75)
- **E-Code** (External cause of injury code) (FL # 77)
- **Principal procedure code** (FL # 80)
- **Other procedure codes** up to 5 (FL #81)
- **Attending physician ID** (FL #82)
- **Other physician ID** (FL #83)

UB92 Data Elements Required for CHARS

UB92 Form Locator (FL#)

3. **Provider's Patient Control Number (PCN):** A patient's unique number assigned by the hospital to facilitate retrieval of individual case records and financial records. Each PCN can have up to 20 characters. It can be an alpha, numeric or alpha/numeric and contain dashes (- -). The hospital must assign a unique number to each record.

4. **Type of Bill:** A code indicating the specific type of bill. Values 111, 121, & 181 are accepted:

Type of facility - first digit:	1 = Hospital
Bill classification - second digit:	1 = Inpatient
	2 = Inpatient (Medicare Part B)
	8 = Inpatient (Swing Beds)
Frequency – third digit:	1 = Admit through discharge claim

111 Hospital Inpatient (Medicare Part A)

121 Hospital Inpatient (Medicare Part B Only)

181 Hospital Swing Beds

6. **Statement Covers Period (From-Through):** The beginning and ending dates of the period included on the UB92. (MMDDYYYY).

12. **Patient Name:** Requires first two letters of patient's last name, first two letters of the patient's first name plus the birth date in the MMDDYYYY format. For Sharon Smith born October 28, 1963, the patient name would be entered as SMSH10281963.

If the first name is unknown, but the initial of the first name is known, use the first two letters of the last name, the first initial of the first name, and a dash (-), or a period (.). For S. Smith born October 28, 1963, the patient name would be entered as either SMS-10281963, or SMS.10281963.

When a patient's last name is a single letter, the patient identifier is the patient's last name plus the first three letters of the first name, plus the birth date. For Sharon S., birthdate of October 28, 1963 the patient name would be entered as SSHA10281963.

For newborns without a first name at the time of discharge, use the first two letters of the last name, "BA" (baby), dashes (--), or periods (..) for the first name plus the

birth date. Examples: Baby Smith could be SMBA10281963, SM--10281963, or SM..10281963.

For multiple births without first names, use the first two letters of the last name, a dash (-) or period (.) in the third character field and A, B, C, etc. in the fourth character field plus the birthdate. Examples: Smith triplets would be SM-A10281963, SM-B10281963, and SM-C10281963 or SM.A10281963, SM.B10281963 and SM.C10281963.

13. **Patient Address (Zip Code Only):** The patient's home address zip code, first five numbers only. If the Zip Code is unknown, assign the hospital's Zip Code. When the patient is from a foreign country use the first five letters of the country's name. This field is either numeric or alpha, not a combination. See Appendix H for a list of approved country codes.

14. **Patient Birth date:** The date of birth of the patient. Format must be MMDDYYYY. If unknown, use June 30 of the estimated year.

15. **Patient Sex:** The sex of the patient as recorded at date of admission or start of care. Use "M" (Male) or "F" (Female).

17. **Admission/Start of Care Date:** The date the patient was admitted to the hospital for inpatient care. MMDDYYYY.

19. **Type of Admission/Visit:** A code indicating the priority of this admission. Values 1-5 are accepted.

1 - Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally the patient was admitted through the emergency room.
2 - Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally the patient was admitted to the first available and suitable accommodation.
3 - Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4 - Newborn	A baby born within this facility. Use of this code necessitates the use of Special Source of Admission Code. See Form Locator 20 below
5-Trauma Ctr	Visit to a trauma center/hospital as licensed or designated by the state or local government authority to do so, or as verified by the ACS and involving a trauma activation.

20 **Source of Admission:** A code indicating the source of this admission. Values 1-9 are accepted. If type of admission is "4", Newborn, use the special source of admission codes for newborns listed below item 9 below.

1 - Physician Referral	The patient was admitted to his facility upon the recommendation of his or her personal physician.
2 - Clinic Referral	The patient was admitted to this facility upon the recommendation of this facility's clinic physician.
3 - HMO Referral	The patient was admitted to this facility upon recommendation of a health maintenance organization (HMO) physician.
4 - Transfer from a Hospital	The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.
5 - Transfer from a SNF	The patient was admitted to this facility as a transfer from a skilled nursing facility (SNF) where he or she was an inpatient (including swingbeds and distinct-part SNF).
6 - Transfer from Another Health Care Facility	The patient was admitted to this facility from a health care facility other than an acute care facility or a SNF. This includes transfers from nursing homes, long term care facilities and SNF patients that are at a non-skilled level of care.
7 - Emergency Room	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
8 - Court/Law Enforcement	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9 - Information Not Available	The means by which the patient was admitted to the hospital is not known.
A – Transfer from a CAH	The patient was admitted to this facility as a transfer from a Critical Access Hospital wherehe/she was an inpatient.
D – Transfer from Hospital	Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer.

Special Source of Admission Codes for Use with Newborns:

1	Normal Delivery	A baby delivered without complications.
2	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.

3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4	Extramural Birth	A newborn delivered in a non-sterile environment.

22. **Patient Status:** A code indicating patient status as of the ending service date of the period covered in this record. The following values are accepted:

01 Discharged to home or self care (routine discharge)

02 Discharged/transferred to short-term general hospital for inpatient care

03 Discharged/transferred to Medicare certified SNF in anticipation of covered skilled care

04 Discharged/transferred to an intermediate care facility (ICF)

05 Discharged/transferred to another type of institution not defined elsewhere in this code list

06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care

07 Left against medical advice or discontinued care

20 Expired

43 Discharged/transferred to a Federal Hospital

50 Hospice – Home

51 Hospice – Medical Facility

61 Discharged/transferred to a hospital based Medicare approved swing bed

62. Discharged/transferred to an inpatient rehabilitation facility including rehab distinct-part units of a hospital

63. Discharged/transferred to a Medicare-certified long term care hospital

64. Discharged/transferred to a Medicaid-certified but not Medicare-certified SNF

65. Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66. Discharged/transferred to a Critical Access Hospital (CAH)

42. **Revenue Codes:** A code that identifies a specific accommodation or ancillary charge. Accommodation codes are identified in the 10x to 21x series. Ancillary

codes are identified in the 22x to 99x series. Professional fees and outpatient revenue codes are not accepted in CHARS and will return an error message when reported. For the list of accepted and unaccepted revenue codes see Appendix D.

CHARS will accept up to 399 revenue code lines and a 400th line designated as the '001' Total Charge. Total charges of all accommodation and ancillary charges should be the last line item listed on the ancillary record type as revenue code '001.' The system does not accept a negative line item charge in data submission files. Negative charges will be recalculated accordingly.

46. **Units of Service:** A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days. CHARS requires the same units as Medicare does, the units of service for accommodation days should equal the length of stay. Where units of service are not required by Medicare, leave zero-filled as the system default.

47. **Total Charges:** Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.

Hand-keyed records into the system will include the '001' Total Charge as the final revenue code reported. Electronic record submissions will include the '001' Total Charge as described in the CMS1450 Version5 Flat File Format shown at Appendix C (reference page C-13: '60' record, field 4, SEE NOTE).

50A **Payer Identification- Source of Payment Code**: Indicates priority of payer, e.g. value 'A' for Primary Payer, value 'B" for Secondary Payer

50B **Payer Identification –** Payer Identification Number identifying each payer group from which the hospital may expect some payment for the bill. Values for CHARS are:

001 Medicare

002 Medicaid (Washington State Department of Social and Health Services-DSHS, Healthy Options, Molina)

004 HMO (Health Maintenance Organization, e.g. Kaiser, Group Health, Basic Health Plan)

006 Commercial Insurance (e.g. Mutual of Omaha, Safeco)

008 Worker's Compensation (includes state fund, self-insured employers, and Labor & Industries crime victim's claims).

009 Self Pay

610 Health Care Service Contractors (e.g. Premera Blue Cross, KPS)

625 Other government sponsored patients (e.g. TRICARE, Indian Health)

630 Charity Care (as defined in WAC 246-453-010)

Secondary Payer: Use the same number values as above.

51. **Provider Number:** The number assigned to the provider by the payer in FL50A or 50B above.

67. **Principal Diagnosis Code:** The ICD-9-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

68-75. **Other Diagnosis Code**: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Up to eight codes are accepted.

77. **External Cause of Injury Code (E-code):** The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect. One code is accepted in the UB92 format. An E-code is required for all 8000-9999 ICD-9-CM codes. A missing E-code will cause CHARS to return an error message. If no E-code is available, the record can be forced using the force form and sending the form to CHARS staff. See the DOH website for the force form.

80. **Principal Procedure Code**: The code that identifies the principal procedure performed during the period covered by this record.

81 **Other Procedure Code**: The codes identifying all significant procedures other than the principal procedure. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. Up to five codes are accepted.

82. Attending Physician ID: The number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and /or who has primary responsibility for the patient's medical care and treatment. CHARS accepts the Medicaid license number, DOH state license number, or Medicare Unique Physician Identifier Number (UPIN).

The Medicaid license number is a seven digit number (e.g., 1864267, 8923655). A number beginning with "7" is a clinic number and is not accepted in CHARS.

The DOH state license number is a 10-digit number starting with the physician's specialty, followed by the number (e.g., MD00040345).

The UPIN begins with an alpha character and has five digits (e.g., A69345). RES000and INT000 are not accepted in CHARS.

83. **Other Physician ID: The number of the licensed physician who performed the principal procedure or performed the surgical procedure most closely related to the principal diagnosis. It may or may not be the same as the attending physician depending on whether the attending physician performed the procedure. CHARS accepts the Medicaid license number, DOH state license number, or UPIN.**

All records containing a procedure code must have a corresponding Other Physician number entered, or the system will return an error message.

Additional Information

Medicare Provider Number

Hospitals with Medicare approved units (e.g., Acute Care, Psychiatric, Rehabilitation, Swing Bed) must use the appropriate Medicare Provider Number for all patients discharged from the unit. A separate processing report is created for each unit. Hospitals designated as Critical Access Hospitals (CAH), must use the appropriate CAH-designated Provider Number for all patients discharged from the hospital.

Swing Beds

The Medicare Provider Number should reflect that it is a Medicare certified swing bed unit. CHARS will accept the "181" swing bed Type of Bill.

Skilled Nursing Beds

CHARS does not collect discharges of skilled nursing beds. They should not be submitted to CHARS.

Mothers and Babies

Hospitals are to submit separate discharge records for mother and baby. All babies born in the hospital, even if the baby stays less than 24 hours, must be reported as a discharge to CHARS.

Late Charges and Adjustments

Late charges and adjustments for individual records can be made electronically when an entire period of time (a month) can be deleted and resubmitted with the corrections made. All prior corrections made for the deleted month will be lost.

Guidelines For Submitting E-Codes

External causes of injury and poisoning (E-Codes) classify environmental events, circumstances, and other conditions as the cause of injury, poisoning, and other adverse effects. Codes E800-E999 should be used when applicable and in addition to a code from the main body of the classification system indicating the nature of the condition.

CHARS requires the reporting of one E-Code when applicable.

All hospital units (Acute, Psych, Rehab, and Swing Bed) should report E-Codes.

CHARS Edit 8282, "Diagnosis indicates trauma or poisoning but no E-Code is present," will return an error message if one of the nine diagnoses is in the 8000-9999 range and an E-Code is not present. CHARS Edit 1286, "An E-Code cannot be used as the principal diagnosis," is created when an E-Code is listed as the principal diagnosis. These edits will return an error message. If the information is not available, and the coder is unable to assign an E code, use the Force Form on the DOH website, enabling CHARS staff to force the record.

A hospital that admits the patient for the codes 8000-9999 is required to submit the E-Code. A hospital that receives the patient as a transfer for the same initial injury is not required to submit an E-Code. Because Form Locator # 20 on the UB92 can indicate transfer as source of admission, users of data can recognize that the patient was a transfer and the E-Code was excluded.

Admission to a Rehab Unit or Hospital can be coded using the "Late Effect" E-Code if applicable. If the patient is transferred to a Rehab Unit or Hospital, and it is a continuation of the initial injury, an E-Code is not required.

General E-Code Coding Guidelines... (Taken from Coding Clinic, Fourth Quarter, 1996)

An E-Code can never be a principal diagnosis.

If two or more events cause separate injuries, an E-Code should be assigned for each cause. (CHARS requires one E-Code) The first listed E-Code will be selected in the following order:

- E-Codes for child and adult abuse take priority over all other E-Codes (see Child and adult abuse guidelines below).
- E-Codes for cataclysmic events take priority over all other E-Codes except child and adult abuse.
- E-Codes for transport accidents take priority over all other E-Codes except cataclysmic events and child and adult abuse.

The first listed E-Code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

Child and Adult Abuse Guidelines

When the cause of an injury or neglect is intentional child or adult abuse (995.50-995.59, 995.80-995.85), the first listed E-Code should be assigned from categories E960-E968, "Homicide and injury purposely inflicted by other persons" (except category E967). An E-Code from category E967, "Perpetrator of child and adult abuse," should be added as an additional E-Code to identify the perpetrator, if known.

In cases of neglect when the intent is determined to be accidental E904.0, "Abandonment or neglect of infants and helpless persons," should be the first listed E-Code.

Unknown or Suspected Intent Guidelines

When it is unspecified or it cannot be determined whether the injuries are accidental (unintentional), suicide (attempted), or assault, use E-Codes 980-989.

Undetermined Cause

When the intent of an injury of poisoning is known, but the cause is unknown, use E-Codes E928.9, "Unspecified accident," E988.9, "Injury of unspecified means," or E968.9, "Assault by unspecified means."

These codes should rarely be used as the documentation in the medical record, in both the inpatient and outpatient settings should normally provide sufficient detail to determine the cause of the injury.

Certification

The requirement for certification of CHARS data is in WAC 246-455-090. “The department shall furnish each hospital a report of its quarterly discharge data contained in the department’s discharge data system. The chief executive officer (CEO) of the hospital shall, within fourteen calendar days of receipt of the report, certify that the information contained in the department’s discharge data system is complete and accurate to within 95% of the total discharges and total charges experienced at the hospital during that quarter, or submit the necessary corrections to the data to permit such certification.”

The certification can include the total of all Medicare approved units for the hospital or each unit can be certified individually.

When the hospital requires more than 14 working days to certify the data, a request for a two week extension should be made to the CHARS staff stating the reason more time is needed and what is being done to correct the situation. A second two week extension may also be requested stating the reason and what is being done to certify.

Monthly processing reports should be reviewed upon receipt to note any discrepancies between the hospital’s and the department’s discharges and charges. Adjustments and corrections should be made if necessary. These corrections should result in a quarterly report with no outstanding errors, and the certification should be easily accomplished.

The CHARS discharges and charges should be approximate to the information submitted to the department’s HPDS Hospital Financial database. CHARS collects discharges and the financial database has admissions.

The department has agreed that if the CEO is unable to sign the form, his/her designee should sign the CEO’s name with a notation of who is signing the report. The department requires notification in writing designating another hospital official with signature authority.

The original form should be returned to the department via postal email, scan or fax, and a copy kept on file at the hospital.

System Inputs

Hospitals, or their vendors, submit patient records to CHARS via the online file submission process or by hand-keying patient records directly into CHARS.

General Input Information

The CHARS system was designed to accommodate the provider billing file and record formats for the National UB92 (CMS1450 Version050 Flat File Format effective October 1, 1998) as documented in Addendum A and Addendum B from the National Uniform Billing Committee (NUBC). CHARS accepts all record types, but does not store every data element included in the UB92 CMS1450 dataset (see Appendix C). Only those elements marked "Required" in the remarks column of the CMS1450 Version050 Flat File Format are stored. Revenue codes excluded from the CHARS system include outpatient services and professional fees. (See Appendix D.) The system accepts data submitted in the 192-character format. The file layout reflects the data elements collected by CHARS as indicated on each record. Except where noted, CHARS follows the *NUBC Data Element Specifications, effective May 9, 2002.*

Data elements that must be included in each submission and in the appropriate record type number (e.g., record 01) according to the CMS1450 Version050 Flat File Format:

1. **Value for Field Name Record Type:** required on each record.
2. **Submitter Tax ID:** Federal Tax ID number for the unit data for which data are submitted (records 01, 95, 99).
3. **Version Code:** value 050 for Version5 (record 01).
4. **Medicare Provider Number:** CMS assigned number for the hospital or hospital unit (record 10).
5. **Patient Control Number:** unique number assigned by the hospital for each discharge, up to 20 characters is accepted (records 20, 30, 40, 50, 60, 70, 80).
6. **Patient's Last Name:** first two letters of patient's last name (record 20).
7. **Patient's First Name:** first two letters of patient's first name (record 20).
8. **Patient's Sex:** M or F (record 20).
9. **Patient's Birth date:** format must be MMDDYYYY (record 20).
10. **Type of Admission:** value must be 1-5 (record 20).

11. **Source of Admission:** value must be 1-9, 'A' or 'D'. If type of admission is 4 indicating newborn, use Special Source of Admission Codes with corresponding values of 1-4 (record 20).

12. **Patient Zip Code:** five numbers. If a foreign country, enter first five letters of the country (record 20).

13. **Admission/Start of Care Date:** MMDDYYYY (record 20).

14. **Statement Covers Period From:** MMDDYYYY (record 20).

15. **Statement Covers Period Through:** MMDDYYYY (record 20).

16. **Patient Status:** values 01-07, 20, 43, 50-51, 61-65 (record 20).

17. **Payer Identification Number**: values 1, 2, 4, 6, 8, 9, 610, 625 and 630 (record 30).

18. **Sequence Number:** only sequence one (primary payer) and sequence two (secondary payer) will be stored in CHARS (records 30, 40, 50, 60, 70, 80, 90).

19. **Type of Bill:** values 111, 121, & 181 (record 40).

20. **Accommodation Revenue Codes:** 10x-21x, a total of 4 line items can be included on one record; multiple records can be submitted (record 50).

21. **Accommodation Days:** number of days the patient was in this unit, total days in all units equal length of stay (record 50).

22. **Accommodation Total Charges:** submitted charge for each revenue code (record 50).

23. **Ancillary Revenue Codes:** total of 3 line items can be included on one record; multiple records can be submitted (record 60).

24. **Ancillary Units of Service:** CHARS requires units if required by Medicare. Other units, if not required by Medicare, may be submitted if desired (record 60).

25. **Ancillary Total Charges:** submitted charge for each revenue code, total charges of all Accommodation and Ancillary charges are listed on Ancillary record 60 as Revenue Code '001' (record 60).

26. **Principal Diagnosis Code:** ICD-9-CM code required. Do not include decimal (record 70).

27. **Other Diagnosis Codes**: ICD-9-CM code. Do not include decimal. Eight codes may be submitted (record 70).

28. **Principal Procedure Code:** ICD-9-CM code, required if applicable. Do not include decimal (record 70).

29. **Other Procedure Codes:** ICD-9-CM code. Do not include decimal. Four codes may be submitted (record 70).

30. **External Cause of Injury:** E-Code, one required for all 8000-9999 ICD-9-CM codes (record 70).

31. **Attending Physician Number:** Medicaid license, DOH state license or UPIN number (record 80). Medicaid license numbers have seven digits and do not begin with a zero, DOH state license numbers have ten digits beginning with a two-letter physician specialty and two zeros, UPIN has one alpha and five digits.

32. **Operating (Other) Physician Number:** Medicaid license, DOH state license, or UPIN number (record 80). Same parameters apply as in Attending Physician Number, above.

33. **Total Accommodation Charges:** of all discharges on this submission (record 90).

34. **Total Ancillary Charges:** of all discharges on this submission (record 90).

35. **Number of Claims:** of all discharges on this submission (record 95).

36. **Number of Batches on this File:** may include multiple hospital units, multiple months (record 99).

37. **Accommodations Total Charges for File:** (record 99).

38. **Ancillary Total Charges for File:** (record 99).

A combined total of 399 line items for Accommodation and Ancillary Revenue Codes and one '001' Total Charge of all Accommodation and Ancillary charges are accepted in the CHARS system for each discharge record.

Input File Validation

Upon receipt, the data submission is verified as follows using the CMS1450 Version 050 Flat File Format:

1. The file begins with a record type 01 and ends with a record type 99;

2. The Submitter Tax ID fields on record types 01, 95 and 99 are identical;

3. The Version Code field on the record type 01 contains "050";

4. Each record type 10 on the file is followed by a record type 95 with the identical value in the field before another record type 10 occurs;

5. The hospital, or the hospital's Medicare certified unit, can be identified by the Medicare Provider Number on record type 10;

6. Each record type 20 on the file is followed by a record type 90 with the identical value in the Patient Control Number field before another record type 20 or record type 95 occurs;

7. All record types between a record type 20 and a record type 90 contain the identical value in the Patient Control Number field that occurs on the record type 20.

If any of the validation requirements are not met, processing is halted and the file is rejected. The hospital CHARS Representative is notified via the CHARS Hospital Log.

If all of the validation requirements are met, the submission is allowed into the system and runs through the Medicare Code Edit process.

The system assigns a unique identifier to each discharge. This is the HPDS Record Key number appearing on the Inpatient Discharge Record screens.

Value Added Data Elements

In addition to the standard data elements input, processed, and stored, the system routinely calculates the following value-added data elements for each patient to aid in outcome measurement and analysis:

Age: the age of the patient is determined by subtracting the birth date from the admission or service from date.

Age Category: the age group the patient fell into when admitted. They are:

Newborn
<1
1-14
15-44
45-64
65-74
75+

DRG (Diagnosis Related Groups): the classification the patient falls into based upon their principal diagnosis, secondary diagnoses, surgical procedures, age, sex, discharge status, and the presence of comorbidities or complications (CCs). The system assigns this value using these criteria and the CMS DRG grouping software in effect at the time of the patient's discharge. DRGs are defined by CMS as groupings of patients who are similar clinically and in terms of their consumption of provider resources.

Provider Service Code: the standard service code assigned to the patient on the basis of principal procedure, principal diagnosis and patient age. Service codes include:

Medical
Surgical
Obstetric
Psychiatric
Pediatric
Newborn

Length of Stay: the length of time in days that the patient was in the facility. It is determined by subtracting the patient's admission date from the discharge date. If the result is zero, the length of stay is set to one day. Leave of absence days are excluded from the length of stay calculation.

MDC (Major Diagnostic Category): the CMS MDC group the patient falls into based upon the patient's principal diagnosis. This code is assigned based on the version of the CMS DRG software in effect at the time of the patient's discharge. MDC groups are defined by CMS as groupings of diagnoses corresponding to a single organ system or etiology and in general are associated with a particular medical specialty.

Operative Class: a Yes/No indicator of whether the patient required the resources of an operating room. CMS determines which DRG typically use these resources and if the patient has an operative procedure.

Payer Identification: the public and confidential data have:

001 = Medicare

002 = Medicaid (DSHS, Healthy Options, Molina)

004 = Health Maintenance Organization (HMO)

006 = Commercial Insurance

008 = Worker's Compensation (includes state fund, self insured employers, and Labor and Industries crime victims claims)

009 = Self Pay

610 = Health Care Service Contractors

625 = TRICARE, Indian Health

630 = Charity Care

The primary and secondary payers, as submitted, are stored in the database.

Total Episode Patient Charges: the total charges the patient incurred for this visit at the hospital. It is the sum of all the patient's ancillary charges and

accommodation charges incurred. Outpatient and certain revenue codes are not accepted. (See exclusion list in Appendix D.)

Data Edits and Data Grading: Clinical or Financial: each edit is designated as clinical (diagnoses, procedures, physicians and demographic data elements) or financial (revenue codes, units, charges).

Record or Batch: all DOH edits are a record type.

Corporate or Specific: each edit is designated as corporate (performed on all records in all submissions, and used for data grading) or specific (performed under specific conditions based on DOH specifications)

After the editing process each record is individually graded. This grade is used to determine what percentage of records is in error. The error percentage is calculated by dividing the total number of records that contain at least one error by the total number of records in the submission. If that percentage is greater than 60%, the file submission is rejected as exceeding the error threshold and noted on the Hospital Log. The goal is for 5% or less error rate.

System Outputs

The following reports are available under the "Reports" tab in the online CHARS system: Other interested parties may obtain a copy of the reports by calling or emailing CHARS Staff.

REPORT NAME	TITLE
HOS0001	Data Quality Format and Edit Summary
HOS0002	Reserved
HOS0003	Reserved
HOS0004	Audit Totals
HOS0005	Reserved
HOS0006	Audit Summary
HOS0007	Hospital Data on File
HOS0008	Pending Hospital Errors
HOS0009	Charge Reconciliation Report
HOS0010	Certification Report
HOS0011	Census by DRG
HOS0012	35 Most Frequent DRGs
HOS0013	35 Most Frequent Diagnosis Codes
HOS0014	35 Most Frequent Procedure Codes
HOS0015	Submission Error Report
SR1_2	Standard Reports 1 and 2